Patient Name _____

DOB _____ **WI#** _____

Back Bay Imaging
301 Bayview Circle, Suite 105
Newport Beach, CA 92660
ph (949) 799-3000 | fax (949) 799-4000

Describe complaints/symptoms for which this exam is being performed: _____

_____

Next appointment date with doctor? _____

Do you presently or have you had any of the following:

CANCER ☐ Yes / ☐ No What Type: _____ When: _____

SURGERY ☐ Yes / ☐ No What Type: _____

When: _____

ASTHMA ☐ Yes / ☐ No Name of Inhaler: _____

ALLERGIES ☐ Yes / ☐ No What Type: _____

DIABETIC ☐ Yes / ☐ No What Medications: _____

KIDNEY DS ☐ Yes / ☐ No Are you on Dialysis? ☐ Yes / ☐ No How Often: _____

HEART DS ☐ Yes / ☐ No Medications: _____

SICKLE CELL ANEMIA ☐ Yes / ☐ No **HYPERTENSION** ☐ Yes / ☐ No

MULTIPLE MYELOMA ☐ Yes / ☐ No

History of smoking? ☐ Yes / ☐ No ____Pk(s)/Day x ____Years Quit? _____ When?_____

Have you had a previous test of the area that is being scanned today? ☐ MRI / ☐ CT / ☐ US / ☐ X-Ray

If yes, when & where: _____

Are you pregnant? ☐ Yes / ☐ No **When was your last menstrual period:** _____

Relating to today's exam, check any of the following that apply:

☐ UNEXPLAINED WEIGHT LOSS	☐ HEADACHES	☐ BLOOD IN STOOL/URINE
☐ CHANGE IN BOWEL HABITS	☐ PAIN	☐ BLADDER/PELVIC DISORDER
☐ NAUSEA/VOMITING	☐ SINUSITIS	☐ KIDNEY STONE
☐ TRAUMA/INJURY	☐ VERTIGO/DIZZINESS	☐ FOLLOW UP TO SURGERY
☐ SCIATICA RT LT	☐ ABN LAB (BLOOD WORK) RESULTS	☐ FOLLOW UP

PATIENT SIGNATURE: _____ **DATE:** _____

BELOW FOR TECH USE ONLY

_____ CTDI: _____ DLP: _____
_____ CTDI: _____ DLP: _____

EXAM: _____ ADDITIONAL HX FROM PATIENT

FOV:_____/_____ TABLE HEIGHT_____/_____ ___Acute ___Chronic ___Initial; ___Subsqnt___Seqnt

TECH:____/_____ RAD:_____ _____

Contrast /Amnt: ____mL Isovue____ ___mL Saline _____

BUN_____ CREAT_____GFR:____ _____

Inj Rate: ____mL/sec _____PSI Cath Size:____ Gg Inj Site: R L Area: __Anti Cub; Other:_____

Patient tolerated injection? YES _____ NO_____ EXPLAIN _____

_____